

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Maryland's application for the renewal of the Waiver for Adults with Traumatic Brain Injury will include the following changes:

The additional criteria for the target group (Appendix B-1:b) has been modified to reflect age of onset of traumatic brain injury after age 17. The previous criteria was traumatic brain injury after age 21.

While there are no other significant changes to the approved waiver included with this renewal application, the Operating State Agency (MHA) and the State Medicaid Agency (OHS) are working with stakeholders on the TBI Waiver Advisory committee and the State TBI Advisory Board to add a new waiver service. The service is a direct nursing service for waiver participants who have stable but chronic nursing care needs that have been unmet through delegation of nursing functions by a Registered Nurse. The TBI Waiver Advisory Committee is working with MHA and OHS to develop a service description and limitations that will enable this new service to be provided without exceeding cost neutrality limits. MHA, OHS and the stakeholders are recommending this change as a strategy to prevent waiver participants from being admitted to nursing facilities for stable and chronic medical conditions.

The stakeholder groups have also recommended changing the definition of traumatic brain injury that is used in the waiver program and will be working with MHA and OHS to develop an alternative definition and analyze the fiscal impact of the change.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A. The State of Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

**Traumatic Brain Injury renewal waiver**

**C. Type of Request:** renewal

**Requested Approval Period:** (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

☐ 3 years ☒ 5 years

☒ **Migration Waiver** - this is an existing approved waiver

☒ **Renewal of Waiver:**

Provide the information about the original waiver being migrated

Base Waiver Number: 40198

Amendment Number

(if applicable):

Effective Date: (mm/dd/yy)

07/01/11

Waiver Number: MD.40198.R01.00

Draft ID: MD.23.01.00

Renewal Number: 01

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/11

**1. Request Information (2 of 3)**

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☒ **Hospital**

Select applicable level of care

☒ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:  
Rehabilitative/chronic/specialty for traumatic brain injury programs

☐ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**☒ **Nursing Facility**

Select applicable level of care

☒ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:  
Not applicable

☐ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

**1. Request Information (3 of 3)**

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

☒ **Not applicable**☐ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates (check each that applies):**

- ☐ §1915(b)(1) (mandated enrollment to managed care)
- ☐ §1915(b)(2) (central broker)
- ☐ §1915(b)(3) (employ cost savings to furnish additional services)
- ☐ §1915(b)(4) (selective contracting/limit number of providers)
- ☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

Specify the program:

#### **H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

- ☐ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## **2. Brief Waiver Description**

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Maryland's Home and Community Based Services Waiver for Adults with Traumatic Brain Injury (referred to as TBI Waiver in this document) was implemented July 1, 2003 and renewed for an additional five years July 1, 2006. The operating state agency (OSA) is the Mental Hygiene Administration (MHA) with oversight from the Office of Health Services, Division of Evaluation and Quality Review (OHS/DEQR). The program was initially designed as a resource for Maryland residents with traumatic brain injury who could not be served in traditional long-term care settings within the state primarily due to the severity of their neurobehavioral deficits.

Events that precipitated the creation of this program include the out of state placement of several individuals with TBI with complex needs and an increasing number of individuals who became "stuck" in state psychiatric hospitals due to the lack of appropriate care alternatives within the State of Maryland. Because the target population was quite specific, the program was intended to be small- 10 slots were approved for the first year, 20 slots for the second, and 30 slots in each year thereafter. Technical eligibility is based on type of injury, age at injury and the location where the applicant is residing. At the start of the program, technical eligibility was limited to individuals in state psychiatric hospitals, out of state placements, or state owned and operated nursing facilities. At the time of the first renewal, technical eligibility was expanded to individuals in chronic hospitals that are CARF accredited for brain injury rehabilitation. This change in eligibility resulted in several outcomes: (1) referrals to the waiver program increased; (2) the needs of the participants transitioning from the chronic hospitals were different from the needs of the early participants, requiring MHA and OHS to look at the design and implementation of waiver services; and (3) enrollment in the TBW became a diversion from traditional long term care options such as nursing facilities and has resulted in positive outcomes for waiver participants.

There are five services available through the TBI Waiver: residential habilitation, day habilitation, supported employment, medical day care and individual support services. Providers are required to be licensed by the Developmental Disabilities Administration and have expertise in the provision of services to individuals with TBI. There is no "enrollment cap" for eligible individuals who meet money follows the individual and/or money follows the person criteria.

## **3. Components of the Waiver Request**

**The waiver application consists of the following components. Note: *Item 3-E must be completed.***

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

- C. Participant Services.** **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- ☐ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

☒ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- ☒ **Not Applicable**
- ☐ **No**
- ☐ **Yes**
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- ☒ **No**
- ☐ **Yes**

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- ☐ **Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.  
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make participant-direction of services as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.  
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

	 
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## 5. Assurances

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In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a

local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.



**I. Public Input.** Describe how the State secures public input into the development of the waiver:

The TBI Waiver Advisory Council meets quarterly to review TBI Waiver quality monitoring activities and outcomes and provides input to MHA and OHS regarding program design. The TBI Waiver Quality Council reports its findings and recommendations to the State TBI Advisory Board.

The TBI Waiver Advisory Council provided input and recommendations to the OHS and MA regarding this 2011 five-year renewal application. OHS and MHA will continue discussions with TBI stakeholders to determine the feasibility of allowing access to the waiver for individuals in private nursing facilities.

Additionally, the Department uses information gathered from the Participant Experience Survey and the complaint and grievance system to determine if changes are needed to the program.

When new or amended regulations or waiver amendments/renewals are proposed by DHMH, a notice is required to be published in the Maryland Register. Regulations may not be promulgated until an opportunity for public comment is provided, including a response from DHMH to all public comments received.

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.**7. Contact Person(s)**

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**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Maryland**

**Zip:**

**Phone:**  **Ext:**  ☐ **TTY**

**Fax:**

**E-mail:**

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:** 55 Wade Avenue  
**City:** Catonsville  
**State:** Maryland  
**Zip:** 21228  
**Phone:** (410) 402-8476 **Ext:**  ☐ TTY  
**Fax:** (410) 402-8304  
**E-mail:** sodea@dhhm.state.md.us

## 8. Authorizing Signature

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This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

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**Signature:** Sandra Brownell  
State Medicaid Director or Designee  
**Submission Date:** Mar 31, 2011

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**Last Name:** Tucker  
**First Name:** Susan  
**Title:** Executive Director, Office of Health Services  
**Agency:** Department of Health and Mental Hygiene  
**Address:** 201 West Preston Street  
**Address 2:**  
**City:** Baltimore  
**State:** Maryland  
**Zip:** 21201  
**Phone:** (410) 767-1430  
**Fax:** (410) 333-5185  
**E-mail:** TuckerS@dhhm.state.md.us

## Attachment #1: Transition Plan

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Specify the transition plan for the waiver:

## Additional Needed Information (Optional)

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Provide additional needed information for the waiver (optional):

Not applicable.

## Appendix A: Waiver Administration and Operation

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### 1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- ☐ **The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- ☐ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- ☐ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- ☒ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

**Mental Hygiene Administration**

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities: **As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the

Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DHMH is the single state Medicaid agency authorized to administer Maryland's Medical Assistance Program. DHMH's OHS oversees the TBI Waiver through its Division of Evaluation and Quality Review (DEQR). In this capacity, OHS oversees the performance of MHA, operating state agency (OSA) for the waiver.

OHS is responsible for monitoring MHA through: 1) Memorandum of Agreement regarding each administration's roles and responsibilities 2) Quality Management Plan that outlines in detail, quality assurance activities and each entity responsible for that activity 3) quarterly reports from MHA on reportable events that include trending and tracking of data and plans for remediation 4) quarterly inter-agency waiver coordination meetings between DEQR and MHA to discuss issues, policy and remediation planning at least on a quarterly basis.

As previous stated, OHS and MHA have developed and implemented a Quality Management Plan, which is based upon assuring waiver participant health and safety through appropriate level of care determinations, monitoring and approving plans of care; enrolling qualified providers; monitoring provider performance and providing training; implementing a system for reporting critical events and complaints, providing administrative oversight and financial accountability.

The DEQR waiver coordinator assigned to the TBI waiver, conducts a semi-annual review of all waiver participants' records which includes a review of each participant's plan of care and issues a report of findings to MHA. If corrective actions are needed, MHA will develop a plan to systematically address each issue.

## Appendix A: Waiver Administration and Operation

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3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:* Medicaid utilizes the services of a contracted Utilization Control Agent. The five-year contract was recently re-bid and the new contractor began work in February, 2011. The new Utilization Control Agent (UCA) contractor was a previous contractor for Medicaid for many years.

For the Medicaid Waiver for Adults with Traumatic Brain Injury, the UCA conducts initial and annual determinations of level of care.

The Mental Hygiene Administration (MHA) utilizes the services of a contracted Administrative Services Organization (ASO) for utilization review and claims payment.

- ☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

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4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ☐ **Not applicable**

- ☒ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- ☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

- ☒ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

Maryland's Mental Hygiene Administration (MHA), the OSA for the TBI Waiver, contracts with one of its Core Service Agencies (local mental health authority / private non-profit agency) to provide enhanced transitional case management services to MFP participants.

## Appendix A: Waiver Administration and Operation

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- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
- There are three non-state entities that perform administrative functions for the TBI Waiver. These are the Core Service Agencies (CSA) that contracts for enhanced transitional case management, Medicaid's UCA, and an Administrative Services Organization (ASO). The MHA has responsibility for assessment of the performance of the CSA and the ASO. OHS is responsible for assessment of the performance of the UCA.

## Appendix A: Waiver Administration and Operation

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- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
- Core Service Agency**  
The MHA Office of Core Service Agency Liaisons is responsible for the oversight of the contract between MHA and the Core Service Agency.

### Administrative Services Organization

ValueOptions, the ASO, is selected and contracted by MHA through a state procurement process to manage the public mental health system. Services provided include utilization management, network management, access to care, claims payment, federal fund attainment, evaluation, data collection, and special projects. After MHA authorizes services ValueOptions pays clean claims for TBI Waiver services to licensed TBI providers. ValueOptions submits claims to MMIS for federal claiming.. MHA's Deputy Director of Community Programs and Managed Care is the contract monitor for the ASO contract. MHA conducts an annual review of the ASO to assure the ASO is providing services as required in its contract with MHA. In addition, representatives of MHA leadership meet with ValueOptions bi-monthly to review contract compliance. Monthly meetings with Maryland Medicaid, MHA and ValueOptions are convened to identify issues to be addressed and to review policies and procedures. ValueOptions' management of the waiver is for claims payment and federal fund collections.

### UCA

OHS contracts with a UCA to perform level of care determinations. The Chief of the Medicaid Division of Long Term Care Services is the contract monitor for UCA contracts. On a quarterly basis, staff performs budget reconciliation for the UCA and review performance statistics. Additionally, there are periodic reviews of the appropriateness of Medicaid level of care determinations by the UCA, which include waiver determinations.

## Appendix A: Waiver Administration and Operation

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- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

**a. Methods for Discovery: Administrative Authority**

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**PM1 Delegated Task: Waiver Enrollment Managed Against Approved Limits – Number and percent of unduplicated participants for whom an Authorization to Participate (ATP) to SMA that remains less than or equal to the number of slots available. N: # unduplicated participants for whom ATP's are issued; D: # of approved slots available**

**Data Source** (Select one):

**Meeting minutes**

If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

PM2 Delegated Task: Waiver expenditures managed against approved levels - Number and percent of participant service plans with the average aggregate cost equal to or less than the

average cost for nursing home/chronic hospital care. N: # of participant aggregate costs equal to or less than the NH/CH average cost; D: # of participants

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-Annually



**Performance Measure:**

**PM3 Delegated Task Level of Care Evaluation: Number and percent of LOC determinations completed by the UCA in 28 days. N: # of LOC determinations completed by the UCA within 28 days; D: # of LOC determinations**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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**Performance Measure:**

**PM4 Delegated Task Review of participant Service Plans: Number and percent of service plans (annual or updated plans) that were authorized by the OSA prior to implementation of services. N: # of service plans authorized prior to implementation of services; D: # of service plans reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually  <input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>  <input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Semi-annually	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually  <input type="checkbox"/> Continuously and Ongoing

☒ **Other**  
Specify:  
Semi-annually

**Performance Measure:**

**PM5 Delegated Task Prior authorization of waiver services: Number and percent of waiver claims paid that were prior authorized by the OSA. N: # of claims paid that were prior authorized; D: # of claims paid**

**Data Source (Select one):****Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**PM6 Delegated Task – Utilization Management: Number and percent of participants with delivery of at least one waiver service per month as specified in the service plan. N: # of participants with at least one service per month; D: # of participants.**

**Data Source (Select one):****Program logs**

If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**PM7 Delegated Task - Qualified provider enrollment: Number and percent of individual findings regarding provider (including staff) qualifications that were appropriately and timely remediated by the OSA. N: # of provider qualification issues appropriately and timely remediated by the OSA; D: # of provider qualification issues identified**

**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**PM8 Delegated Task – Rules, Policies, Procedures and Information Development Governing the Waiver Program: Number and percent of policies and/or procedures developed by OSA that were reviewed and approved by the SMA prior to implementation. N: # of policies & procedures developed by the OSA reviewed by Medicaid Agency before implementation; D: # of policies & procedures developed**

**Data Source (Select one):****Meeting minutes**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and</b>	<b>Frequency of data aggregation and analysis</b>
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<b>analysis (check each that applies):</b>	<b>(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**PM9: Delegated Task – Quality Assurance and Quality Improvement Activities: Number and percent of Reportable Events (RE's) that were appropriately resolved by the OSA within the timeframe standard established by DDA's Policy on Reportable Events (PORI). N: # of RE's appropriately resolved by the OSA within the established timeframe standard; D: # of RE's received by the OSA**

**Data Source (Select one):****Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation(check each that applies):</b>	<b>Frequency of data collection/generation(check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify:	

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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

PM1: The OSA reviews the number of approved participants and the number of available slots on a monthly basis and sends the data to the SMA on a monthly basis. The data will be reviewed during quarterly inter-agency coordination meetings.

If the OSA fails to send monthly reports of approved applicants and available slots, the first incident would be remediated with a letter from the SMA Division Chief to OSA Division Chief with a reminder of the OSA's responsibility to comply with monthly reporting. Further incidence of non-compliance would be remediated through the CAP process.

PM2: During the semi-annual audit of the OSA's participant files, the SMA will check the cost-neutrality of each waiver participant's service plan. The OSA will should devise a cost-neutral service plan that will allow the participant to be safely maintained in the community prior to being approved for the waiver.

PM3: The contract with the UCA requires that 95% of LOC determinations be completed within 28 days. If the data review finds that the UCA has completed less than 95% of the cases within the required time frame of 28 days, the Contract Monitor will inform the UCA and request explanatory information on each determination that was not timely. There are a number of external factors that may affect the timeliness of a determination such as a late response to a request for more information or clarification by the UCA. If the contractor is responsible for the lack of timeliness corrective action will be taken. Corrective will include, but is not limited to, requiring the implementation of a correction plan or retracting payment from the UCA if non-compliance continues after a corrective action plan has been put in place.

If the review finds that the UCA has completed less than 95 percent of the cases within the required time frame, the Contract Monitor will inform the UCA and request explanatory information on each determination that was not

timely. If the contractor is responsible for the lack of timeliness corrective action will be taken. Corrective will include, but is not limited to, requiring the implementation of a correction plan or retracting payment from the UCA if non-compliance is high and/or repetitive.

PM4: The SMA will verify that services are not being rendered prior to being authorized by the OSA by comparing data gather during the semi-annual participant audit review and claims data from MMIS. Any service that is rendered prior to authorization is not eligible for reimbursement and will be recovered from waiver providers. If the pattern continues, a CAP will be requested from the provider as well as the OSA from non-compliance.

PM5: The SMA will verify claims are not being paid prior to them being authorized by the OSA by comparing data gather from the participant audit review and claims data from MMIS. Any service that is rendered prior to authorization is not eligible for reimbursement and will be recovered from waiver providers. If the pattern continues, a CAP will be requested from the provider as well as the OSA from non-compliance.

PM6: SMA receives monthly reports from MMIS detailing monthly claims paid for each waiver service and participant. If a waiver participant has not received a waiver service in more than a month a letter will be sent to the OSA requesting documentation why the participant has not received a waiver service. If the review finds that the participant has not received a waiver service for a legitimate reason then the participant will be discharged from the waiver.

Participants are eligible to reenter the waiver during the same waiver year of the individual meets all eligibility requirements of the waiver.

PM7: During the provider audits that the SMA and the OSA conduct yearly personnel files are examined to ensure that all providers and their staff are in compliance with all requirements for participation. If providers are not in compliance a letter detailing their non-compliance will be issued by the OSA and a CAP will be requested.

PM8: Any new policy or procedure change will be discussed at quarterly inter-agency meetings between the OSA and the SMA. If policy and procedures are being implemented and changed prior to the SMA's approval a letter will be sent from the SMA to the OSA and a CAP will be requested.

PM9: SMA is required to present quarterly summaries of Reportable Events data with analysis to the SMA. An important aspect of the report is information regarding the initiation of remediation. If the OSA quarterly report reveals remediation has not been initiated, the SMA will require a CAP from the OSA.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ No

☐ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="radio"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input checked="" type="checkbox"/>	Brain Injury	22	<input type="text"/>	<input checked="" type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="radio"/> <b>Mental Retardation or Developmental Disability, or Both</b>					
	<input type="checkbox"/>	Autism	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Mental Retardation	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="radio"/> <b>Mental Illness</b>					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

- b. **Additional Criteria.** The State further specifies its target group(s) as follows:

\*Individuals aged 22 through 64, who at the time of qualifying injury and admission to the waiver but once admitted, may remain past the age of 64 so long as the other waiver eligibility criteria are met. Waiver services are limited to individual's diagnosed with traumatic brain injury that was sustained after age 17. Participant must be discharged into waiver services from a stay in a State psychiatric hospital that is determined to be inappropriate, including individuals funded in community placements by the Department's Mental Hygiene Administration with all state funds, or from a Medicaid placement in an out-of-State CARF-accredited hospital or from a nursing facility owned and operated by the state, or from a Maryland licensed Special Hospital for Chronic Disease with TBI & CARF Accreditation.

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

☒ **Not applicable. There is no maximum age limit**

- ☐ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ☐ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- ☐ A level higher than 100% of the institutional average.

Specify the percentage:

- ☐ Other

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

The cost limit specified by the State is (*select one*):

- ☐ The following dollar amount:

Specify dollar amount:

**The dollar amount** (*select one*)

- ☐ Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

- ☐ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- ☐ The following percentage that is less than 100% of the institutional average:

Specify percent:

- ☐ Other:

Specify:

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The Medical Eligibility Review Form (DHMH 3871) is completed for each waiver applicant by his/ her treating physician as part of the initial waiver application. The assessment package is sent to MHA for review. MHA sends the package to the Department's utilization control agent (UCA) for a medical eligibility determination. Once the level of care is determined, MHA contacts TBI waiver providers to submit a service plan for the waiver applicant. Providers meet with the applicant to assess whether they can serve the individual safely in the community. MHA will not approve a plan of care that cannot meet the health and safety needs of the individual in the community.

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- ☐ The participant is referred to another waiver that can accommodate the individual's needs.
- ☐ Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☒ Other safeguard(s)

Specify:



All opportunities to revise the POC will be explored if a participant can no longer be served in a cost neutral manner. For example, if adding personal support hours pushes costs over the cost neutrality limit because the participant is less able to care for themselves, the use of residential habilitation services can be explored. If an individual needs additional services for a temporary period of time, the Department can approve those services in order to continue to serve the individual in the program. If the period of time becomes more permanent (more than 4-6 months) or the costs threaten the overall cost neutrality of the program, the individual will be disenrolled. In the event there is no solution available, the case manager will develop a discharge plan with the participant and representative/s, which may include referring the participant to AERS to provide detailed assistance in identifying non-waiver community resources and other support services. The Medicaid unit of the local department of social services is also a typical referral source when there are issues of Medicaid eligibility or planning needs to begin for financing long term care placement in a nursing facility if appropriate. In some cases it is clearly evident that a nursing facility placement is appropriate and acceptable to the participant and the case manager will provide guidance in how to locate a nursing facility in their community.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	64
Year 2	76
Year 3	88
Year 4	100
Year 5	112

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- ☒ The State does not limit the number of participants that it serves at any point in time during a waiver year.
- ☐ The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):
- ☒ **Not applicable. The state does not reserve capacity.**
  - ☐ **The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- ☒ **The waiver is not subject to a phase-in or a phase-out schedule.**
  - ☐ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. **Allocation of Waiver Capacity.**

*Select one:*

- ☒ **Waiver capacity is allocated/managed on a statewide basis.**
- ☐ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry into the waiver is based upon the date of the applicant meeting all of the criteria for participation in the program: technical eligibility, medical eligibility and financial eligibility.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

- a.
1. **State Classification.** The State is a (*select one*):
    - ☒ **§1634 State**
    - ☐ **SSI Criteria State**
    - ☐ **209(b) State**
  2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- ☒ No  
☐ Yes

- b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

---

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

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- ☒ Low income families with children as provided in §1931 of the Act  
☒ SSI recipients  
☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121  
☒ Optional State supplement recipients  
☐ Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- ☐ 100% of the Federal poverty level (FPL)  
☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)  
☒ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)  
☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)  
☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)  
☐ Medically needy in 209(b) States (42 CFR §435.330)  
☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)  
☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

*Specify:*

Individuals eligible for AFDC/TCA due to requirements that do not apply under title XIX (42CFR§435.113).

Individuals who meet the income and resource requirements of the cash assistance programs (42CFR§435.210).

Pregnant and postpartum women at or below 250% of FPL included in the State Plan (1902(a)(10)(A)(ii)(IX) and 1902(l) of the Social Security Act).

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***Special home and community-based waiver group under 42 CFR §435.217*** Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

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- ☐ No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.  
☒ Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

*Select one and complete Appendix B-5.*

- ☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217

- ☒ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies:*

- ☒ **A special income level equal to:**

*Select one:*

- ☒ **300% of the SSI Federal Benefit Rate (FBR)**  
☐ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ☐ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**  
☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**  
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**  
☐ **Aged and disabled individuals who have income at:**

*Select one:*

- ☐ **100% of FPL**  
☐ **% of FPL, which is lower than 100%.**

Specify percentage amount:

- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

- ☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- ☒ **Use spousal post-eligibility rules under §1924 of the Act.**  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**  
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ☐ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**  
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

#### b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

#### i. Allowance for the needs of the waiver participant (*select one*):

- ☒ **The following standard included under the State plan**

*Select one:*

- ☐ **SSI standard**
- ☐ **Optional State supplement standard**
- ☐ **Medically needy income standard**
- ☒ **The special income level for institutionalized persons**

(*select one*):

- ☒ **300% of the SSI Federal Benefit Rate (FBR)**
- ☐ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ☐ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ☐ **A percentage of the Federal poverty level**

Specify percentage:

- ☐ **Other standard included under the State Plan**

*Specify:*

- ☐ **The following dollar amount**

Specify dollar amount:  If this amount changes, this item will be revised.

- ☐ **The following formula is used to determine the needs allowance:**

*Specify:*

- ☐ **Other**

*Specify:*

---

ii. **Allowance for the spouse only** (*select one*):

---

- ☐ **Not Applicable**
- ☐ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:*

**Specify the amount of the allowance** (*select one*):

- ☐ **SSI standard**
- ☐ **Optional State supplement standard**
- ☐ **Medically needy income standard**
- ☐ **The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised.

- ☐ **The amount is determined using the following formula:**

*Specify:*

---

iii. **Allowance for the family** (*select one*):

---

- ☐ **Not Applicable (see instructions)**
- ☐ **AFDC need standard**
- ☐ **Medically needy income standard**
- ☐ **The following dollar amount:**



Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ☐ **The amount is determined using the following formula:**

Specify:

- ☐ **Other**

Specify:

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☒ **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☐ **The State does not establish reasonable limits.**
- ☐ **The State establishes the following reasonable limits**

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 4)

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 4)

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the

contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(select one):

- ☐ SSI standard
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☐ The special income level for institutionalized persons
- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ The following dollar amount:

Specify dollar amount:  If this amount changes, this item will be revised

- ☐ The following formula is used to determine the needs allowance:

*Specify formula:*

- ☐ Other

*Specify:*

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- ☐ Allowance is the same
- ☐ Allowance is different.

*Explanation of difference:*

**iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☒ **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☐ **The State does not establish reasonable limits.**
- ☐ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

**ii. Frequency of services.** The State requires (select one):

- ☐ **The provision of waiver services at least monthly**
- ☒ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

Not applicable.

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):

- ☐ **Directly by the Medicaid agency**
- ☐ **By the operating agency specified in Appendix A**
- ☒ **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

The Department's Utilization Control Agent (UCA).

- ☒ **Other**  
*Specify:*

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The State Medicaid agency contracts with a UCA that is a Quality Improvement Organization to determine a waiver applicant's LOC. The UCA employs licensed registered nurses to certify nursing facility LOC. The UCA employs a physician as does OHS, who will assist in the determination of LOC when there are unusually complex or contested decisions by the nurse reviewers. All LOC determinations are subject to review and approval by the Medicaid agency.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care

instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The same medical eligibility standard is applied to waiver participants as to individuals seeking approval for institutional services. The contractor uses a standardized LOC evaluation tool to assess each applicant for nursing facility or chronic hospital level of care called the 3871.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- ☐ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ☒ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

Medicaid has developed an alternative format to the 3871 called the 3871B which is a scoreable instrument used to determine nursing facility level of care. However, the 3871 captures the information used to determine either nursing facility or chronic hospital level of care. Since the TBI waiver has both a nursing facility and chronic hospital level of care, the Department uses the same instrument for evaluating both levels of care covered under the program.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Medical Eligibility Review Form (DHMH 3871) is used by the UCA to evaluate TBI Waiver applicants' level of care. The 3871 form is part of the initial TBI Waiver application and the TBI Waiver reevaluation packet, which are sent to waiver applicant's designee/representative. MHA provides assistance with the completion of these forms. MHA receives the completed form and faxes the form and supporting medical documentation to UCA where the level of care evaluation is determined and the results are faxed to MHA. The process takes less than one week unless documentation to make the determination is insufficient. The process is the same for annual reevaluations.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- ☐ **Every three months**
- ☐ **Every six months**
- ☒ **Every twelve months**
- ☐ **Other schedule**

*Specify the other schedule:*

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- ☒ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ☐ **The qualifications are different.**

*Specify the qualifications:*

- i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The Medicaid Eligibility Status Report Unit sends a quarterly notice to MHA of waiver redeterminations that are due in the upcoming three months to the administrator of each home and community based waiver program. The notices for the TBI waiver are sent to MHA. These reports are shared with the TBI Waiver Case Manager who facilitates the completion of the reevaluation packet within 60 days. When complete, the TBI Waiver Case Manager sends a new medical eligibility review

form to the UCA 14 days prior to the expiration date to ensure that the waiver participant continues to meet the waiver program's medical eligibility criteria.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

MHA stores all documentation related to evaluations and reevaluations in the waiver applicant's/ participant's permanent record, which is stored at the MHA headquarters for a minimum of three years.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### a. Methods for Discovery: Level of Care Assurance/Sub-assurances

##### i. Sub-Assurances:

- a. **Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

#### Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Number and percent of new participants who received a LOC before initiation of services;**  
**numerator- number of individuals who received a LOC before initiation of services;**  
**denominator- total number of individuals who initiated services.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**UCA reports, semi- annual OHS audit**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi annually	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input checked="" type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annually

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of participants who receive an annual LOC redetermination within 12 months of the most recent LOC; numerator- number of participants who received a LOC determination within 12 months of most recent LOC; denominator- total number of enrolled waiver participants.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**semi-annual OHS audit**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: semi-annually	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: semi-annually

- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of participants' LOC determinations that were completed using the approved medical eligibility criteria; numerator- number of LOC determination that were completed using the approved eligibility criteria; denominator- total number of LOC determinations that were completed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**LTC/ Nursing unit LOC reviews**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):



<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of participant LOC determinations that are completed by designated Utilization Control Agent (UCA); numerator- number of LOC determinations that are completed by designated Utilization Control Agent (UCA); denominator- total number of LOC determinations that were completed.

**Data Source (Select one):****Operating agency performance monitoring**

If 'Other' is selected, specify:

**semi-annual OHS audit**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annually	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: semi-annually

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. OHS/ DEQR conducts semi-annual audit of MHA's (OSA) waiver records. During these audits, OHS checks to make sure that LOC determinations are completed prior to start of waiver services for new participants and within 12 months of the last LOC determination for participants who have been enrolled for more than one year. OHS also checks to make sure that the LOC determination is completed by the Department's designated UCA. OHS LTC/ Nursing unit reviews a sample of LOC determination completed by the UCA to ensure that they were completed using the approved eligibility criteria.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
If during the semi-annual audit, OHS discovers deficiencies related to LOC determinations, OHS requires MHA to fix the problem by requesting a level of care review from the designated UCA. Errors must be fixed and documented in the corrective action plan (CAP) within 30 days of completion of the audit.

The OHS validates a percentage TBI Waiver LOC decisions monthly. If during the validation review it is determined that a LOC determination was incorrect, the applicant or participant continues to receive services pending the outcome of a new evaluation. The UCA is consulted and an investigation is initiated to determine why the LOC was incorrect. When appropriate, a corrective action plan is requested.

**ii. Remediation Data Aggregation****Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

☐ Continuously and Ongoing

☒ Other
Specify:  
semi-annually
**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The TBI Waiver Case Manager assists the waiver applicant and/or representative in completing a Freedom of Choice (FOC) form which requires the applicant to choose between institutional and community-based services. This FOC form also indicates the choices of services and providers that are available through the TBI Waiver. The application packet is not considered complete and the applicant will not be enrolled in waiver services until the FOC form is signed.

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed FOC form, along with the other application forms, are stored for a minimum of three years in the participant's permanent waiver record located at MHA's office. Application forms, including the FOC form, are also stored for a minimum of three years for those individuals who are determined not eligible for the TBI Waiver.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The state provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters at no cost to individuals, and translations of forms and documents. Additionally, interpreter resources are available for individuals who contact DHMH for information, requests for assistance or complaints. The DHMH website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community. The State also provides translation services at fair hearings if necessary. If an LEP appellant attends a hearing without first requesting services of an interpreter, the administrative law judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Day Habilitation
Statutory Service	Individual Support Services
Statutory Service	Medical Day Care
Statutory Service	Residential Habilitation
Statutory Service	Supported Employment

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

**Alternate Service Title (if any):**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

**Service Definition (Scope):**

The covered services shall include: (1) Habilitative or rehabilitative services to assist a participant in acquiring, regaining, retaining, or improving the self-help skills related to activities of daily living and the social and adaptive skills, which are necessary to reside successfully in home and community-based settings; (2) Meals are furnished as part of the program; (3) Any of the following additional services which are provided at the provider's site, are medically necessary to prevent the participant's institutionalization, and are not otherwise covered for the participant by the Program or another payer: (a) Nursing supervision, in accordance with the Maryland Nurse Practice Act and COMAR 10.27.11 for medication administration or other delegated nursing functions provided to the participant by a qualified direct care worker; and (b) Behavior intervention services; and (4) Transportation between a participant's residence and the provider's site, or between habilitation sites if the participant receives habilitation services in more than one place. (1) Services provided in a day habilitation program shall be provided and reimbursed at one of three levels of service, as preauthorized in the participant's waiver plan of care approved by the MHA.

Level 1 requires a minimum of 1:6 staff to participant ratio.

Level 2 requires a minimum of 1:4 staff to participant ratio.

Level 3 requires a minimum of 1:1 staff to participant ratio.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The program shall reimburse for a participant not more than one unit of day habilitation per day or a combined maximum of five units of supported employment and day habilitation per week. The program does not cover recreational activities not related to specific treatment goals or are solely diversional, or for activities or supervision reimbursed for a source

other than Medicaid. The program does not pay for day habilitation on the same date of service as on-site psychiatric rehabilitation as defined in COMAR 10.21.21 and COMAR 10.21.25. The program does not pay for day habilitation on the same date of service as adult medical day care provided under COMAR 10.09.07.

**Service Delivery Method** (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

**Specify whether the service may be provided by** (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Day Services Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type:** Statutory Service  
**Service Name:** Day Habilitation

**Provider Category:**

Agency

**Provider Type:**

Day Services Provider

**Provider Qualifications**

**License** (*specify*):

DDA Vocational and Day Services COMAR 10.22.07

**Certificate** (*specify*):

**Other Standard** (*specify*):

Additional years of experience with TBI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Healthcare Quality (OHCQ) and Mental Hygiene Administration (MHA)

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Personal Care

**Alternate Service Title (if any):**

Individual Support Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

**Service Definition (Scope):**

Assistance provided to an individual to enable participation in the community, which may include, but are not limited to, supports involving:1) Budgeting2) Medication Administration3) Counseling4) Helping an individual to access and complete the individual's education5) Participating in recreational and social activities6) Accessing community services7) Grocery shopping8) Behavioral, and other services and supports needed by the family of the individual, and9) Developing relationships

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Participants may receive up to 200 hours per month of Individual Support Services. There are no limits on duration of service.

**Service Delivery Method (check each that applies):**

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	ISS Provider

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Individual Support Services****Provider Category:**

Agency

**Provider Type:**

ISS Provider

**Provider Qualifications****License (specify):**

Family and Individual Support Services license through DDA. Provider is qualified to provide services under Maryland Regulation, COMAR 10.22.02 and 10.22.06

**Certificate (specify):**

**Other Standard (specify):**

Additional years of experience with TBI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Office of Healthcare Quality (OHCQ) and Mental Hygiene Administration (MHA)

**Frequency of Verification:**  
Annually

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

Medical Day Care

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

**Service Definition (Scope):**

Medical Day Care is a program of medically supervised, health-related services provided in an ambulatory setting to medically handicapped adults who, due to their degree of impairment, need health maintenance and restorative services supportive to their community living.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

A. Medical Day Care includes the following services:

- (1) Health care services supervised by the director, medical director, or health director, which emphasize primary prevention, early diagnosis and treatment, rehabilitation and continuity of care.
- (2) Nursing services performed by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse.
- (3) Physical therapy services, performed by or under supervision of a licensed physical therapist.
- (4) Occupational therapy services, performed by an occupational therapist.
- (5) Assistance with activities of daily living such as walking, eating, toileting, grooming, and supervision of personal hygiene.
- (6) Nutrition services.
- (7) Social work services performed by a licensed, certified social worker or licensed social work associate.
- (8) Activity Programs.
- (9) Transportation Services.

B. The Program will reimburse for a day of care when this care is:

- (1) Ordered by a participant's physician semi-annually;
- (2) Medically necessary;
- (3) Adequately described in progress notes in the participant's medical record, signed and dated by the individual providing care;
- (4) Provided to participants certified by the Department as requiring nursing facility care under the Program as specified in COMAR 10.09.10;
- (5) Provided to participants certified present at the medical day care center a minimum of 4 hours a day by an adequately maintained and documented participant register; and
- (6) Specified in the participant's service plan.

A Waiver participant must attend the MDC a minimum of 4 hours per day for the service to be coverable. The frequency of attendance is determined by the physician orders and is part of the service plan developed by the multi-disciplinary team. The waiver participants cannot attend day habilitation or supported employment on the same day as MDC.

**Service Delivery Method** (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

**Specify whether the service may be provided by** (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Medical Day Care

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type:** Statutory Service  
**Service Name:** Medical Day Care

**Provider Category:**

Agency 

**Provider Type:**

Medical Day Care

**Provider Qualifications**

**License** (*specify*):

OHCQ

**Certificate** (*specify*):




**Other Standard** (*specify*):

Providers must meet the requirements of COMAR 10.09.07 for medical Day Care Waiver providers.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The DHMH is responsible for verification in addition to the OHCQ

**Frequency of Verification:**

At time of enrollment and every two years during licensing reviews.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service 

**Service:**

Residential Habilitation 

**Alternate Service Title (if any):**






Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

**Service Definition (Scope):**

The covered services shall include: (1) Residential habilitation means assistance with acquisition, retention, or improvement in skills related to activities of daily living, personal care and the social and adaptive skills necessary to enable the individual to live in a non-institutional setting with protective oversight.(2) Supervision and support, up to 24 hours a day, in a residence, based on the individual's plan of care; and (3) Any of the following additional services which are medically necessary to prevent the participant's institutionalization and are not otherwise covered for the participant by the Program or another payer: (a) Nursing supervision, in accordance with the Maryland Nurse Practice Act and COMAR 10.27.11 for any medication administration or other delegated nursing functions provided to the participant in the residence by a direct care worker; and (b) Behavior intervention services. The residential habilitation services provider shall provide daily coordination of the participant's clinical treatment, rehabilitation, health, and medical services with the other providers of TBI waiver services and the TBI waiver case manager. Services provided in a residential program shall be provided and reimbursed at one of three levels of service, as pre-authorized in the participant's waiver plan of care approved by the MHA.

Level 1 requires a minimum of 1:3 staff to participant ratio during day and evening shifts and nonawake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift.

Level 2 requires a minimum of 1:3 staff to participant ratio during day and evening shifts and awake, on-site supervision during overnight shift.

Level 3 requires a minimum of 1:1 staff to participant ratio during the day and evening shifts and awake, on-site supervision during overnight shift.

Residential Habilitation is a service that allows providers to be reimbursed for absence days up to 15 days per episode not to exceed a total of 30 days of absence annually per individual. Such payment is intended to maintain an individual's residential habilitation placement during periods of absence due to circumstances including family visitations, hospitalizations, or other overnight stays.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The program shall reimburse for a participant not more than one unit of residential habilitation for a date of service. The program does not cover room and board for an unrelated personal caregiver who lives with the participant, direct payments to the participant's family, or activities or supervision reimbursed for a source other than Medicaid. The program does not cover payment for residential habilitation on the same date of service as personal care provided under COMAR 10.09.20. Additionally, the program does not cover absence days more than 15 days per episode not to exceed a total of 30 days of absence annually per individual.

**Service Delivery Method (check each that applies):**

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Residential Services Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

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**Service Type: Statutory Service**  
**Service Name: Residential Habilitation**

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**Provider Category:**Agency **Provider Type:**

Community Residential Services Provider

**Provider Qualifications****License (specify):**

DDA Community Residential Services COMAR 10.22.08

**Certificate (specify):**



**Other Standard (specify):**

Additional years of experience with TBI as required in COMAR 10.09.46 or CARF accredited for provision of brain injury services.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Office of Healthcare Quality (OHCQ) and Mental Hygiene Administration (MHA)

**Frequency of Verification:**

Annually

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## Appendix C: Participant Services

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### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**Statutory Service **Service:**Supported Employment **Alternate Service Title (if any):**




Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

**Service Definition (Scope):**

Supported employment means activities needed to support paid work by individuals receiving waiver services, including supervision and training.

Level 1 requires that staff members provide daily contacts to the waiver participant.

Level 2 requires that staff members provide a minimum of 1 hour of direct support per day.

Level 3 requires that staff members provide continuous support for a minimum of 4 hours of service per day.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The program shall reimburse for a participant not more than one unit of supported employment per day or a combined maximum of five units of supported employment and day habilitation per week. The program does not cover incentive payments, subsidies, or unrelated incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to participants in a supported employment program, payments for vocational training that is not directly related to a participant's supported employment program, or for activities or supervision reimbursed for a source other than Medicaid. The program does not

pay for supported employment on the same date of service as mental health vocational supported employment under COMAR 10.21.28.

**Service Delivery Method** (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

**Specify whether the service may be provided by** (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Employment Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type:** Statutory Service

**Service Name:** Supported Employment

**Provider Category:**

Agency

**Provider Type:**

Supported Employment Provider

**Provider Qualifications**

**License** (*specify*):

DDA Vocational and Day Services COMAR 10.22.07

**Certificate** (*specify*):

Mental Hygiene Vocational Program- Supported Employment COMAR 10.21.28

**Other Standard** (*specify*):

Additional years of experience with TBI as required in COMAR 10.09.46

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Office of Healthcare Quality (OHCQ) and Mental Hygiene Administration (MHA)

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-*

I-c.

☒ **As an administrative activity.** Complete item C-1-c.

- c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The State Operating Agency-Mental Hygiene Administration

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

DHMH regulations require providers to conduct criminal background checks for all employees and contractual employees. The scope of the investigations are State of Maryland only. The Office of Health Care Quality checks to ensure that the criminal background checks are completed during the annual provider site visits. MHA also checks employee records for evidence of criminal background checks during their provider site visits.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ☒ **No. The State does not conduct abuse registry screening.**
- ☐ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

- c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** Select one:

- ☐ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ☒ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

- i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Group Home	
Alternative Living Unit	

- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Home and community character is maintained in residential facilities serving 4 – 8 individuals in the same manner as it is for smaller facilities. Participants reside in individual bedrooms when possible, participants are encouraged to decorate the home and their bedrooms with items of their choice. Every effort is made to encourage participants to plan the menu, grocery shop and prepare meals. Every participant is encouraged to build relationships in the community and is given access to transportation for community activities of their choice. Participants are encouraged when possible, to assist with daily household responsibilities such as setting the table, doing the dishes, completing laundry and vacuuming.

## Appendix C: Participant Services

### C-2: Facility Specifications

#### Facility Type:

Group Home

#### Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Individual Support Services	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Medical Day Care	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>

#### Facility Capacity Limit:

8

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>

Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

Not applicable.

## Appendix C: Participant Services

### C-2: Facility Specifications

#### Facility Type:

Alternative Living Unit

#### Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Individual Support Services	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Medical Day Care	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>

#### Facility Capacity Limit:

3

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>

Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

Not applicable.

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☐ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☒ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☐ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ☐ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ☐ **Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Provider enrollment for the TBI Waiver program is an open process. Providers can apply to become TBI Waiver providers at any time. Providers can enroll by requesting a provider enrollment packet from MHA. Completed applications are then returned to the MHA for review and approval. The Mental Hygiene Administration is continuing to recruit qualified providers who have experience serving individuals with TBI. Recruitment efforts include regional training and information sessions about the TBI Waiver program and provider requirements, individual training and meetings with interested provider agencies, advertisements about the waiver program in the Developmental Disabilities Provider's newsletter, presentations at Developmental Disabilities Administration's regional provider meetings, and conducting presentations at various trainings and conferences throughout the State.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### a. Methods for Discovery: Qualified Providers

##### i. Sub-Assurances:

- a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

#### Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Number and percent of providers who meet the required licensing standards prior to initiation of services; numerator- number of providers who meet licensing standards prior to initiation of services; denominator- total number of active waiver providers.**



**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**provider application**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percent of active providers who continually meet the required licensing standards; number of active waiver providers who continually meet the required licensing standards; denominator- total number of active waiver providers.

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**provider audits**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: annual provider audits staggered throughout the year	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

☐ Other

Specify:

**Performance Measure:**

Number and percent of providers that employ or contract with staff, by type, that meet credentialing and criminal background check requirements; Numerator- number of providers that employ or contract with staff, by type, that meet credentialing and criminal background check requirements; Denominator- total number of active waiver providers.

Data Source (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**provider audits**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: annual provider audits staggered throughout the year	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of providers who met provider training requirements according to the approved waiver requirement; Numerator- number of providers who met provider training requirements according to the approved waiver requirement; Denominator- total number of active waiver providers.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**provider audits**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: annual provider audits staggered throughout year	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. OHS and MHA conduct annual provider audits. The audits are staggered throughout the year. During these audits, provider licenses are reviewed and staff credentials, background checks & training are reviewed. Participant records are also reviewed at this time.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
When the State discovers that a provider does not meet licensing standards, the State immediately terminates the

Medicaid provider's enrollment and participants are transferred to another licensed provider.

When the State discovers that a provider does not meet participation standards, the State immediately informs the provider and requests a corrective action plan, within 30 days, that brings the provider into compliance with qualifications. Training and technical assistance is offered to the provider by the OSA to assist with regaining compliance with program qualifications. When appropriate, funds will be recovered. Follow-up occurs to ensure the corrective action plan has been implemented by the provider.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☐ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

- ☐ **Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**  
Plan of Care (POC)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☐ **Registered nurse, licensed to practice in the State**  
☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**  
☐ **Licensed physician (M.D. or D.O)**  
☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)  
☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

Education: Master's degree in Social Work or social service field, or Bachelor's degree in social service field with a minimum of two years of experience in case management or resource coordination, knowledge and understanding of brain injury, relevant work experience with individuals with brain injury and good communication skills.

- ☐ **Social Worker.**

*Specify qualifications:*

☐ **Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards. *Select one:***

- ☒ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Waiver participants are provided with a choice of waiver services, waiver providers, and the choice of institutional versus community-based services. This freedom of choice is documented on the FOC form. Their choices of services and providers as well as their personal goals are documented on the waiver plan of care, which is implemented once signed by the participant or his or her legal guardian.

Prior to enrollment, waiver applicants meet face to face with an enhanced transitional case manager who provides them with information about the waiver program, assists with completing the waiver application, and assists with the transition from institutional setting to community-based services. The case manager develops the provisional plan of care with the waiver participant prior to enrollment in services and then finalizes the plan of care at the 30 day meeting.

Plan of care meetings are always scheduled with waiver participants and their natural supports if they choose to include them. Waiver providers and the waiver case manager also attend POC meetings.

MHA is in the process of improving its person-centered planning process by providing support and tools to waiver participants to assist them with developing their personal goals prior to the POC meeting. MHA is also going to provide person-centered planning training to approved TBI waiver providers.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)



- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The assessment process has two parts. The TBI Waiver Case Manager delegates the initial assessment to the individual's current treating team who has the most accurate information and established, therapeutic relationships with the waiver participant. A provisional plan of care is developed from this initial assessment for the first 30 days in the community which addresses the participant's behavioral health and somatic needs along with the plan for each identified need. During this 30 day period, the provider and the TBI waiver case manager assess the participant's level of functioning in the community setting. A formal plan of care is developed in a face-to-face meeting with the TBI Waiver Case Manager, the participant and the new treatment team at the provider site. The plan of care includes participant strengths and areas of need, health and safety risks and risk management plan, participant goals, waiver and Medicaid non-waiver State plan services such as outpatient health services. The expected frequency and duration of the services, the providers of services, and the projected costs of the waiver services are also included in the POC. The POC reflects the participant's desired services and supports as well as the participant's behavioral health and somatic needs as assessed by the treating physician, the provider, the waiver case manager, the participant and participant's family or natural supports. The waiver case manager meets with the waiver participant at least quarterly to assess the adequacy of the plan of care and make changes as needed. The waiver participant is also given the opportunity to include his/her natural support network in the process. If the applicant has a guardian or authorized representative, that person is automatically included in the process and required to sign the plan of care.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to participants are assessed by the applicant's treatment team in the facility including the treating physician, the community waiver provider, and the case manager prior to enrollment in the program through review of medical documentation and a face-to-face assessment of the waiver applicant. The identified health and safety risks and the medical and behavioral supports that are needed to support the participant safely in the community are documented in the plan of care (POC) and reviewed during the POC meeting within 30 days of enrollment in the program. Specific strategies for dealing with each identified risk are reflected in the POC. The POC includes emergency back-up plans containing information about provider on-call systems for nursing, psychiatric care, programmatic systems and emergency medical care.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

TBI Waiver participants and/or their representatives are given a choice of service providers and can choose what providers they would like to have provide those TBI services. Waiver participants are given copies of the service proposals submitted by TBI waiver providers, which includes a description of the TBI waiver services, the living situation, opportunities for social support, and access to medical supports. To facilitate the applicant's choice of waiver provider and services, each waiver provider conducts a face-to-face visit with each waiver applicant in order to answer specific questions about their programs. They also arrange a tour of their program for the waiver participant and his/her family so that the applicant is able to make an informed choice.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The service plan is developed and is subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i) through the terms of the draft Memorandum of Agreement between OHS and MHA. The OHS TBI Waiver Coordinator conducts annual reviews of a sample of waiver plans of care to assure compliance with the waiver proposal and Medicaid regulations.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

*Specify the other schedule:*

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- ☐ Medicaid agency
- ☒ Operating agency
- ☐ Case manager
- ☐ Other

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Participants are offered a range of services and supports through both the TBI Waiver and Medicaid State Plan services to maintain the participant safely in the community. The TBI Waiver Case Manager works with each participant to develop a waiver plan of care, coordinates the delivery of waiver services in accordance with the plan of care, and updates the plan of care as necessary. Additionally, the case manager reviews provider service reports, such as the participant's individual plan (IP) to monitor service utilization and conducts the annual assessment of participant needs and eligibility. The TBI Waiver

Case Manager conducts quarterly site visits. These visits include a face-to-face meeting with each waiver participant to review the POC and ensure that the participants are satisfied with waiver services including feeling safe in their surroundings. An on-site program review is also conducted to review and monitor the staff ratios at provider sites. These quarterly visits are the catalyst for determining whether changes are needed to the waiver participant's plan of care.

**b. Monitoring Safeguards. Select one:**

- ☒ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

**i. Sub-Assurances:**

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver participants whose plan of care addresses health and safety risk factors; Numerator- Number of plans of care that address health and safety risk factors; Denominator- total number of plans of care.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**OHS annual audit**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annually	

**Data Source** (Select one):**Provider performance monitoring**

If 'Other' is selected, specify:

**annual provider audit**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: annual audits staggered throughout the year	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>  <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b> <input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver participants whose plan of care addresses assessed needs;**  
**Numerator-** number of plans of care that address assessed needs; **Denominator-** total number of waiver plans of care.

**Data Source** (Select one):**Provider performance monitoring**

If 'Other' is selected, specify:

**annual provider audits**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

	<input checked="" type="checkbox"/> <b>Other</b> Specify: annual audits staggered throughout the year	
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**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**OHS semi-annual audits**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annual audit	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>

	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annual for OHS audits
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**Performance Measure:**

**Number and percent of wavier participants whose plan of care addresses personal goals;**  
**Numerator-** number of plans of care that address personal goals; **Denominator-** total number of plans of care

**Data Source (Select one):****Operating agency performance monitoring**

If 'Other' is selected, specify:

**semi-annual OHS Audits**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annual	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; width: 200px; height: 20px; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>

<input type="checkbox"/> Continuously and Ongoing
<input checked="" type="checkbox"/> Other Specify: semi-annual

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

### Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

### Performance Measure:

**Number and percent of participants whose cost of plan of care services are within the waiver cost neutrality limits; Numerator- number of participants whose costs of POC are within waiver cost neutrality limits; Denominator- total number of waiver participants.**

Data Source (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**semi-annual OHS audit**

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify:	



	semi-annual	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: semi-annual

**Performance Measure:**

Number and percentage of waiver participants that attend their Plan of Care meeting;

Numerator- number of waiver participants that attend their plan of care meeting;

Denominator- total number of waiver participants.

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

semi-annual OHS audit

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

☒ **Other**  
Specify:  
semi-annual

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annual

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of plans of care that were updated annually; Numerator- number of participant's plans of care that were updated annually; Denominator- total number of plans of care.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**semi-annual OHS audit**

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: semi-annually	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: semi-annual

**Performance Measure:**

Number and percent of participants' plans of care that were updated when the waiver participants' needs changed; Numerator- number of participants' plans of care that were updated when the waiver participants' needs changed; Denominator- number of waiver participants who were found to have a change in needs requiring change in plan of care.

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**quarterly case management visits**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<b>Agency</b>		
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100 % Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample Confidence Interval =</b> <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of participants' services that are provided in accordance with the plan of care (including the type, scope, amount, duration, and frequency); Numerator-number of waiver services that are provided in accordance with the plan of care (including the type, scope, amount, duration, and frequency); Denominator-total number of waiver services provided.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**quarterly case management visits**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**annual provider audits-ad hoc claims report to be obtained prior to provider audit. auditors will check proportionate random selection of paid claims (by provider) against provider records.**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<b>Agency</b>		
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100 % Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: proportionate random sample
	<input checked="" type="checkbox"/> <b>Other</b> Specify: annual providers audits staggered throughout the year	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of participants who have a signed consent form indicating choice of waiver services versus institutional care, choice of services and choice providers;**

**Numerator- number of participants who have signed consent form indicating choice of waiver services versus institutional care, choice of services and choice of providers;**

**Denominator- total number of waiver participants.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**semi-annual OHS audit**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: semi-annually	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

Specify: <input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annually

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The state uses three primary strategies to discover/ identify problems and issues within the waiver program related to plans of care. First, the waiver case manager(s) conduct announced and unannounced quarterly visits with 100% of waiver participants to ensure that services are being provided in accordance with the plan of care and to assess whether the POC needs to be updated. Second, OHS and MHA conduct annual audits with waiver providers to review 100% of participant records to ensure that the waiver plans of care address participants' needs. These annual provider audits are staggered throughout the fiscal year. A representative sample of claims are matched against attendance records and clinical records to determine if services were provided as authorized. Third, OHS audits the waiver participant records that are located at MHA on a semi-annual basis to ensure that waiver POCs address participants' personal goals, include health and safety risk factors, are within cost-neutrality limits, and are updated at least annually, and that waiver participants are given a choice of waiver services and providers and that they attend their POC meetings.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If problems are discovered during quarterly case management visits or during the annual provider audits related to the plans of care or the provision of waiver services, providers are required to immediately correct the service and/or case manager is required to schedule a meeting to update the plan of care within 2 weeks. When appropriate, such as underdelivery of services to a waiver participant, funds will be recovered.

If problems are discovered during the semi-annual OHS audit related to plans of care or the freedom of choice form, the OSA is required to make the corrections and provide evidence of the correction via the Corrective Action Plan submitted to OHS within 30 days.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annually



**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

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**Applicability** (from Application Section 3, Components of the Waiver Request):

- ☐ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☒ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

- ☐ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ☒ **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## Appendix E: Participant Direction of Services

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### E-1: Overview (2 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## Appendix E: Participant Direction of Services

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### E-1: Overview (3 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (5 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## **Appendix E: Participant Direction of Services**

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### **E-2: Opportunities for Participant Direction (1 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## **Appendix E: Participant Direction of Services**

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### **E-2: Opportunities for Participant-Direction (2 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## **Appendix E: Participant Direction of Services**

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### **E-2: Opportunities for Participant-Direction (3 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## **Appendix E: Participant Direction of Services**

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### **E-2: Opportunities for Participant-Direction (4 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## **Appendix E: Participant Direction of Services**

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### **E-2: Opportunities for Participant-Direction (5 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## **Appendix E: Participant Direction of Services**

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### **E-2: Opportunities for Participant-Direction (6 of 6)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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## **Appendix F: Participant Rights**

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### **Appendix F-1: Opportunity to Request a Fair Hearing**

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Medicaid provides broad Fair Hearing Rights and appeal rights to individuals who are denied choice of HCBS waiver services as an alternative to institutional care, denied services or providers of their choice, and whose services are denied, suspended, reduced or terminated. Specifically, COMAR 10.01.04 which governs Fair Hearings stipulates that the opportunity for Fair Hearing will be granted to individuals who aggrieved by any Department or delegate agency policy, action or inaction which adversely affects the receipt, quality or conditions of medical assistance. Each waiver participant receives a copy of the notice of fair hearing in the initial wavier application upon enrollment. The waiver participant is notified in writing that services will be continued during the appeal process. Process for Giving Notice to Applicants/Participants: If an applicant or enrolled participant is denied waiver eligibility – medical, technical or financial criteria – he/she and any representative that has been identified by the individual are sent a letter that contains the reason for the denial and a Fair Hearings notice. The Medicaid waiver eligibility unit sends all eligibility denial letters. Denial letters are copied to the case manager who will maintain this documentation as part of the participant's waiver record. The waiver eligibility unit also maintains a copy. When a participant is aggrieved by a decision regarding his services or providers, the case manager is responsible for providing the participant and representative with a notice identifying the action or inaction that the participant believes is impacting him/her adversely. This written notice contains the Medicaid fair hearing rights. This notice is maintained by the case manager in the participant's waiver record.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- ☐ No. This Appendix does not apply
  - ☒ Yes. The State operates an additional dispute resolution process
- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Office of Health Services operates the reconsideration process for medical eligibility denials. When an applicant or participant is denied medical eligibility, there is a provision for the individual to request a reconsideration while preserving the right to a Fair Hearing. The reconsideration process allows the individual to clarify medical information already provided regarding their health and functional status, or to provide additional information that was not included at the time of application. The Department's Utilization Control Agent informs the applicant/participant in writing that he/she may request a reconsideration and maintain the right to a Fair Hearing or elect to request a Fair Hearing without the interim process of reconsideration. The letter contains the Program's standard notice with regard to Fair Hearing rights.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. **Operation of Grievance/Complaint System.** *Select one:*
- ☐ No. This Appendix does not apply
  - ☒ Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver
- b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Operating State Agency- Mental Hygiene Administration

- c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The grievance/complaint system ensures the identification of and the appropriate and timely resolution of administrative service and quality of care complaints related to waiver participants. A complaint is defined as any communication, oral or written from a participant, participant's representative, provider, or other interested party to any employee of MHA expressing dissatisfaction with any aspect of MHA or provider's operations, activities, or behavior, regardless of whether any remedial action is requested. Administrative, service related and quality of care complaints are reviewed. Quality of care complaints include, but are not limited to: concerns about perceived practitioners or provider's qualifications or competence, adverse experiences, poor outcomes, inadequate care or perceived harm, provider negligence with regards to policy and procedures, medical record documentation and confidentiality issues as well as accessibility and/or availability, which impact care. TBI Waiver participants are provided with a written summary of the complaint process and how to file a complaint during the initial POC meeting. MHA assists the participant as needed in completing forms. MHA will track all grievances/complaints. The process used for resolving grievances/complaints begins with the MHA representative documenting the pertinent information and the nature of the complaint on the grievance/complaints Action Report. The MHA representative addresses the issue according to the time frames outlined below. The MHA representative completes the initial investigation, and then in conjunction with the participant, family and other related parties, performs all other necessary follow-up, summarizes the finding, and determines and implements the appropriate action steps. This information will be documented on the grievance/complaints action report and submitted to the Office of Health Services Division of Waiver Programs within 30 days. Timeframes for resolving complaints are as follows: 24 hours: emergency medically related complaints, 5 days: non-emergency medically related complaints and 30 days: administrative service delivery complaints. Participants or their representatives will be notified of the disposition of the complaint and right to appeal as appropriate. Results will also be reported to the participant/representative and provider as appropriate. If the participant indicates that he/she is not satisfied with the response, the agency must respond in writing within 30 calendar days from the date of the agency's initial response. Individuals will be informed by the TBI Waiver Case Manager at the initial plan of care meeting that they may file an appeal for a Fair Hearing directly to the Office of Administrative Hearings. Filing a complaint or grievance is not a pre-requisite for requesting a Fair Hearing.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- ☒ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- ☐ **No. This Appendix does not apply** (*do not complete Items b through e*)
- If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All TBI waiver providers are licensed by the Office of Health Care Quality (OHCQ) under the Developmental Disabilities Administration (DDA) regulations and required to follow the Policy on Reportable Incidents set forth by the DDA and updated October 2007. The purpose of the policy is to protect the rights of individuals served by licensed providers by requiring providers to identify, report, investigate, review, correct, and monitor situations and events that threaten the health, safety or well being of individuals receiving services. The policy describes the types of incidents that the provider must investigate internally and /or report to outside agencies as well as time frames for reporting and requirements for follow-up or correction. The policy specifically addresses incidents of abuse, neglect, death, hospital visits, injury, theft, medication errors, leave without notification, incidents requiring law enforcement or the fire department, as well as other incidents.

TBI waiver providers are required to follow this policy and to notify OHCQ, DDA and MHA of a reportable incident within 24 hours by sending a copy of the report. The policy clearly informs providers of the requirement to report all allegations of abuse

or neglect to the Office of Health Care Quality, the Developmental Disabilities Administration, Mental Hygiene Administration, the State's Protection and Advocacy System, Child/Adult Protective Services, and local law enforcement. Additionally, the policy requires providers to submit a report within 21 days to DDA regarding the outcome and follow-up of the incident.

The Policy on Reportable Incidents also requires that internally investigated incidents, those significant events or situations outlined in the policy that shall be reported to designated authorities by the service provider, must also be reported to DDA and OHCQ. Internally investigated events are outlined in the Policy for Reportable Incidents and include events such as physical aggression, planned hospital admissions, minor abrasions, blisters, sunburn, etc. that require minor routine treatment, etc. Internally investigated incidents must be reported to the service provider's director, or designee, within 1 working day of discovery. In addition, the service provider must immediately investigate each incident. Within 21 working days, an internal final report must be completed by the service provider and forwarded to the service provider's standing committee for review. If the investigation reveals that an injury was the result of abuse, neglect, or restraint, this information must be reported as a reportable incident. Each incident must be resolved by the service provider. Each service provider must submit to DDA and OHCQ a listing of all internally investigated incidents which occurred during the prior quarterly period. The reports are due January 15, April 15, July 15, and October 15. In the event that 3 or more internally investigated incidents occur within a 4 week time frame for the same individual, the most recent incident must be treated as a reportable incident and investigated accordingly. Documentation regarding the other incidents shall be included in this report.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Rights and Responsibilities form, which includes information related to participants' right to be free from abuse and neglect, is completed and signed by the waiver applicant/designee prior to enrollment and annually during the redetermination process. This form includes instructions related to reporting complaints and/or critical incidents to the Mental Hygiene Administration Office of Adult Services.

The Case Manager schedules a waiver plan of care meeting within the first thirty days of enrollment into the TBI waiver for the waiver participant and their family. At the initial and annual plan of care meetings, the Case Manager reviews the participant Rights and Responsibilities form with the waiver participant.

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Waiver providers are required to report any critical events or incidents to MHA within 24 hours by sending a copy of the Reportable Incidents Report to the Office of Health Care Quality, DDA and MHA. Some reportable incidents must also be reported to other external entities such as the Maryland Disability Law Center (Maryland's Protection and Advocacy Organization), law enforcement, etc. MHA uses a reportable incident action report form which includes a summary of the findings, action taken by the provider or MHA and recommendations to improve the quality of care for waiver participants. Additionally, waiver providers are required to submit a report within 21 days to MHA regarding the outcome and follow-up of the incident.

The licensed provider is responsible for communicating the results of a critical incident investigation to a waiver participant and their family or guardian following the investigation report's completion, and, when appropriate, engage the individual and their family/guardian in follow-up planning and activities to prevent a future occurrence of the critical incident. MHA reviews all reportable incidents and written 21-day reports, provides any needed follow-up, files the reports, and then tracks and trends these incidents on a quarterly basis. The trend reports are sent to OHS each quarter where they are reviewed. Results of trend analysis may result in program changes, including the provision of provider training, based on information received from reports as appropriate. On an annual basis, compiled incident report data will be reviewed and linked to systemic performance improvement efforts as part of the waiver quality management plan.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The responsibility of reporting and response to critical incidents is shared by the OHCQ, DDA, and MHA. The provider is required to send copies of any critical incidents to all three entities. The state agencies conduct annual site visits of TBI waiver providers to ensure their compliance with the critical incident reporting system among other regulations. The OHCQ conducts investigations as necessary pertaining to a critical incident and the reports are shared with MHA and OHS. The Waiver Case Manager also conducts quarterly site visits with the TBI waiver participants and these visits serve as additional oversight. Lastly, the OHS reviews the quarterly incident report trends submitted by MHA as yet another checkpoint in the process. The

Quarterly incident report is shared with the Waiver Quality Council which meets on a quarterly basis. The Council is comprised of at least one waiver representatives from each of the various HCBS waivers and other internal stakeholders including OHCQ. The Council reviews all reportable event quarterly data at each meeting with its members and makes recommendations including policy and regulatory changes based on an analysis of the data and input from the members.

When problems are found with critical incidents, OHCQ, may request additional information and/or conduct an on-site investigation. If non-compliance is identified, providers may receive technical assistance, be requested to submit a plan of correction for the deficient practice, or other remedies may be imposed based on the nature of the deficient practice(s).

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

**a. Use of Restraints or Seclusion. (Select one):**

- ☐ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- ☒ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

TBI waiver providers are licensed by the Office of Health Care Quality (OHCQ) under the Developmental Disabilities Administration (DDA) and are expected to adhere to the regulations set forth in the policy for behavior support services according to COMAR 10.22.10. These regulations state that formal behavior plans (BP) are in place for any waiver participant who may require it due to challenging behaviors. The BP must be developed in conjunction with a licensed professional (i.e. psychologist, behavior analyst) with experience in applied behavior analysis. Any use of restraint or seclusion must be addressed in the BP and may be used only when less restrictive techniques have been tried and failed and when an individual's behavior poses a danger to self or others. The provider must collect and present objective data to the individual's health care practitioner (i.e. the individual's physician and/or psychiatrist) authorizing the use of the restrictive technique to indicate whether it is being used effectively to reduce challenging behavior. All BP's must be approved by the provider's Standing Committee charged with monitoring human rights and include the waiver participant's informed consent prior to being implemented.

The DDA has extensive regulatory requirements governing the development of behavior plans, use of restrictive techniques, use of medications to monitor challenging behaviors, use of physical restraint, use of mechanical restraint and support, and use of chemical restraint. The emergency use of restraints and seclusion is used only for the protection and life safety of the waiver participant and others. The waiver providers are required to report and document the use of emergency restraints in accordance with the policy for critical incidents and follow the same reporting procedures, which include informing OHCQ, DDA, and MHA within 24 hours.

Regulations specify that a licensed provider must ensure that a Behavior Plan (BP) is developed for each individual for whom it is required and is developed, in conjunction with the team, by a licensed psychologist, psychology associate under the supervision of a licensed psychologist, licensed physician, licensed certified social worker, or licensed or certified professional counselor, who has training and experience in applied behavior analysis. The BP must be based on and includes a functional analysis or assessment of each challenging behavior as identified in the IP; specify the behavioral objectives for the individual, and include a description of the hypothesized function of current behaviors, including their frequency and severity and criteria for determining achievement of the objectives established. The BP must take into account the medical condition of the individual; describe the treatment techniques and when the techniques are to be used; specify the emergency procedures to be



implemented for the individual with a history of exhibiting behaviors that present a danger to self or serious bodily harm to others; and include a description of the adaptive skills to be learned by the individual that serve as functional alternatives to the challenging behavior or behaviors to be decreased. As well, the BP must identify the person or persons responsible for monitoring the BP; specify the data to be collected to assess progress towards meeting the BP's objectives; and as part of data collection, ensure that each use of mechanical and physical restraint, the reason for its use, and the length of time used is described and documented.

Before implementation, the licensee must ensure that each behavior plan which includes the use of restrictive techniques is: approved by the standing committee as specified in COMAR 10.22.02.14E(1)(d); and includes written informed consent of the individual, the individual's legal guardian, or the surrogate decision maker as defined in Health-General Article, §5-605, Annotated Code of Maryland.

The licensed provider must ensure that the use of restrictive techniques in any BP: represents the least restrictive, effective alternative, or the lowest effective dose of a medication; and is only implemented after other methods have been systematically tried, and objectively determined to be ineffective. The licensed provider must ensure that staff do not use: any method or technique prohibited by law, including aversive techniques; any method or technique which deprives an individual of any basic right specified in Health-General Article, 7-1002--7-1004, Annotated Code of Maryland, except as permitted in COMAR 10.22.04.03A; seclusion; a room from which egress is prevented; or a program which results in a nutritionally inadequate diet. In addition, staff may not use a restrictive technique as a substitute for a treatment plan, as punishment, or for convenience.

Specific regulations address practices and safeguards relating to:

- Use of Medications to Modify Challenging Behavior (10.22.10.07)
- Use of Physical Restraint (10.22.10.08)
- Use of Mechanical Restraint and Support (10.22.10.09)
- Use of Chemical Restraint (10.22.10.10)

In addition to training specific to an individual's BP, all individuals providing behavioral supports and implementing a BP must receive training on the principles of behavioral change and on appropriate methods of preventing or managing challenging behaviors (10.22.10.04). The DDA formed a Statewide Behavioral Supports Committee (SBSC) whose mission is to promote and monitor the safe, effective and appropriate use of behavior change techniques through recommendations to the DDA, and includes DDA's Statewide Training Coordinator, BPS Master Trainer(s), a representative of OHCQ, licensed psychologist(s) and psychiatrist(s); regional training coordinators; behavioral data experts; and a self-advocate, family member or advocate. The SBSC meets at least quarterly, and is responsible for reviewing information regarding the provision of behavior support services throughout the state and making recommendations to the DDA regarding best practices. The SBSC is also responsible for overseeing the implementation of the BPS curriculum. The BPS curriculum is intended to provide staff who work with individuals with developmental disabilities basic knowledge about the principles of behavior change, strategies for the enhancement of pro-social functional skills, prevention of incidents of challenging behavior, and safe procedures for physical intervention when behavior presents a danger to self or others. The main focus of the program is prevention. The use of physical intervention is stressed as a last resort to terminate behavior that presents a danger to self or others. The physical interventions taught in the curriculum have undergone intense scrutiny to provide an approach which balances the safety and rights of the individual exhibiting the behavior with the safety of others involved in the situation. The DDA has created a Behavioral Principles and Strategies Protocol which provides the operational and procedural guidelines for the Behavioral Principles and Strategies training program.

All use of restraints and restrictive techniques must be documented in the individual's record, including the setting events/reason for use. ABC data (antecedent, behavior, consequence) is reviewed as part of monitoring of the behavior plan.

Detection of unauthorized use of restraints is done in several ways:

- If, as part of the Person-Centered Planning or IP development process, it is discovered that an individual has been exhibiting challenging behaviors, Case Managers probe further for details of the behaviors, including possible antecedents and consequences (i.e. any use of restrictive techniques);
- Case Managers monitor that the IP is being implemented and participants' health and welfare needs are met. Part of this monitoring includes an ongoing general assessment of the person's behavioral support needs done within the scope of their expertise and advocating for the individual to assure that the individual's rights are protected (10.22.09.04);
- Each DDA regional office has a Quality Assurance Review Team (QART) made up of staff who conduct on-site interviews with individuals and provider agency staff during visits and who ascertain that services, including



behavioral support services, are delivered in accordance with Individual Plans and that the participant is satisfied with services being received. The DDA QART surveys every DDA provider at least once per year and, as part of the survey, reviews IPs and supporting documentation to ensure the IP is current (i.e. addresses any current behavioral challenges), meets all of the requirements of COMAR 10.22.05, and is being implemented as written;

- The Office of Health Care Quality (OHCQ) also annually surveys a minimum of 5% of individuals served by DDA providers, monitoring their Individual Plans' and supporting documentation to ensure compliance with all COMAR regulations, including COMAR 10.22.10 -- Behavior Support Services Program Service Plan;
- As part of the Critical Incident Reporting process, OHCQ investigates critical incidents, including those that may have stemmed from the unauthorized use of a restraint or other restrictive technique.

Problematic results from any of the above discovery processes may be addressed in a number of fashions including a citation from OHCQ, requirements for further team planning which may necessitate a change to an individual's POC and the development of a BP, required changes to a provider's policy or procedure or the imposition of deficiencies and/or sanctions to a community provider which ensures completion and implementation of a plan of correction

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

TBI waiver providers are licensed by the Developmental Disabilities Administration (DDA). DDA designates the Office of Health Care Quality (OHCQ) to license and monitor DDA providers and to ensure compliance with state regulations. The OHCQ Developmental Disabilities Unit is responsible for overseeing the use of restrictive interventions for participants living in homes licensed by DDA. OHCQ completes annual surveys and investigations as necessary depending upon the severity of the reportable incident. MHA conducts annual visits with each waiver provider to assure compliance with TBI waiver regulations. At this visit, MHA reviews the most recent OHCQ site visit report to assure that issues identified at that visit were addressed.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

**b. Use of Restrictive Interventions. (Select one):**

- ☐ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

	 
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- ☒ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

TBI waiver providers are licensed by the OHCQ under the DDA regulations and are expected to adhere to their regulations in COMAR 10.22.10. These regulations state that formal behavior plans (BP) are in place for any participant who may require it due to challenging behaviors. The BP must be developed in conjunction with a licensed professional with experience in applied behavior analysis. The BP must address the need for any restrictive techniques and represent the least restrictive, effective alternative or the lowest effective dose of medication. The provider must collect and present objective data to the health care practitioner authorizing the use of the restrictive technique to indicate whether it is effective in reducing the waiver participant's challenging behavior. All BP's must be approved by the provider's human rights committee and include the waiver participant informed consent prior to being implemented.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

TBI waiver providers are licensed by the Office of Health Care Quality (OHCQ) under the Developmental Disabilities Administration (DDA) regulations. The OHCQ Developmental Disabilities Unit is responsible for overseeing the use of restrictive interventions for participants living in homes licensed by DDA. OHCQ completes at a minimum an annual on site survey and conducts investigations as necessary depending upon the severity of the reportable incident. MHA shares the information with OHS at quarterly waiver quality council meetings and any concerns are addressed immediately following an incident.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. **Applicability.** Select one:

- ☐ **No. This Appendix is not applicable** (do not complete the remaining items)  
☒ **Yes. This Appendix applies** (complete the remaining items)

- b. **Medication Management and Follow-Up**

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

All approved TBI waiver providers are licensed by the Developmental Disabilities Administration (DDA) and required to follow the DDA regulations regarding Medication Management. The policy is based on the Nurse Practice Act. TBI waiver providers are responsible for administering medications to waiver participants who are unable to self-administer their medications. The provider is required to maintain current physician orders for all medications that are to be administered to a TBI waiver participant, assist the individual with obtaining medications from a licensed pharmacy, and assist with administering the medications. The TBI Waiver provider's nurse oversees the process during 45 day nursing reviews and reviews of the participant's medication administration record, physician orders, and medications.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

There are three state agencies involved with monitoring the approved TBI waiver providers and ensuring that medications are managed properly for participants: the Developmental Disabilities Administration (DDA), the Office of Health Care Quality (OHCQ), and the Mental Hygiene Administration (MHA). DDA's quality assurance team conducts annual site visits of all licensed providers to provide technical assistance to providers to develop and maintain effective systems (e.g. medication management) for serving individuals. OHCQ conducts annual regulatory site visits to assure that providers are providing services in accordance with DDA regulations. Review of participant's medical charts, medication administration records, physician orders, and nursing assessments and services, and staff medication administration training are part of this annual survey. MHA conducts annual visits with each waiver provider to assure compliance with TBI waiver regulations. At this visit, MHA reviews the most recent OHCQ site visit report to assure that issues identified at that visit were addressed. MHA also reviews waiver participant's medical records to assure that medication administration is being safely managed by the provider.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

- c. **Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- ☐ **Not applicable.** *(do not complete the remaining items)*
- ☒ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.**  
*(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DDA regulations (COMAR 10.22.02.12) that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, state that providers must develop and adopt written policies and procedures for ensuring that medications are administered in accordance with the practices established by DDA's curriculum on medication training. The DDA curriculum is in compliance with the Nurse Practice Act, and includes procedures for monitoring and assisting individuals with self-administering medications. All TBI Waiver provider nurses and staff who administer medications are trained on this curriculum. All nurses additionally must comply with applicable Board of Nursing regulations including the Nurse Practice Act. The Nurse Practice Act gives nurses the ability to delegate the task of administering medication to appropriately trained staff.

**iii. Medication Error Reporting.** *Select one of the following:*

- ☒ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

OHCQ, DDA, MHA, and the Board of Nursing as applicable.

(b) Specify the types of medication errors that providers are required to *record*:

All known medication errors must be recorded.

(c) Specify the types of medication errors that providers must *report* to the State:

Any medication error that results in an individual requiring medical or dental observation or treatment by a physician, physician's assistant or nurse, any medication error that results in the admission of an individual to a hospital or 24-hour infirmary for treatment or observation must be reported.

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The responsibility of monitoring the performance of waiver providers in the administration of medication is shared by OHCQ, DDA, and MHA. All three state agencies conduct annual site visits of TBI waiver providers to ensure their compliance with the medication administration regulations. Applicable reports from DDA, OHCQ and MHA are reviewed during the quarterly meetings. OHCQ may conduct on-site visits based on a significant reportable medication error incident. OHCQ staff may request a plan of correction for an identified deficient practice(s) or other remedies may be imposed based on the severity of the deficient practice(s). Additionally, significant medication incidents reported to the Board of Nursing will be investigated by that agency and actions against a provider and/or individual

may be taken based on the investigative findings. Those actions may include licensure/certification suspension and/or revocation. Significant findings reports or remedies against a provider of waiver services are shared with OHS staff. Reportable incident data is also shared with the Waiver Quality Council on a quarterly basis.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

#### a. Methods for Discovery: Health and Welfare

*The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Number and percentage of participant REs (incidents and complaints), by type, reported within RE timeline; Numerator- number of participant REs (incidents and complaints), by type, reported within RE timeline; Denominator- total number of REs reported to OSA.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percentage of participants abuse, neglect exploitation REs (events and complaints) that follow-up was conducted in accordance with the RE policy; Numerator- number of participants abuse, neglect exploitation REs (events and complaints) that follow-up was conducted in accordance with the RE policy; Denominator- total number of REs reported to OSA.

**Data Source (Select one):****Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	<b>Ongoing</b>	Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percentage of participants who received education on how to report the REs at enrollment; Numerator- number of participants who received education on how to report the REs at enrollment; Denominator- total number of participants enrolled in waiver.

**Data Source** (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Semi-annual OHS audit**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annually	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: semi-annually

**Performance Measure:**

**Number and percentage of waiver participants who receive annual physical in accordance with DDA policies; Numerator-** number of waiver participants who receive annual physical in accordance with DDA policies; **Denominator-** total number of waiver participants enrolled in waiver.

**Data Source** (Select one):**Provider performance monitoring**

If 'Other' is selected, specify:

**annual provider audit**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: provider audits are annual provider audits are staggered throughout the year	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percentage of waiver participants who receive 45 day nursing assessments in accordance with DDA policies; Numerator-** number of waiver participants who receive 45 day nursing assessments in accordance with DDA policies; **Denominator-** total number of waiver participants enrolled in waiver.

**Data Source** (Select one):**Provider performance monitoring**

If 'Other' is selected, specify:

**annual provider audit**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative</b>



		<b>Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: annual provider audits are staggered throughout the year	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. REs are logged and tracked by the OSA. Quarterly summary of REs and compliance with RE policy is sent to OHS.

Quarterly case management visits provides an opportunity for the case manager to discover unreported REs. This discovery information is sent to OSA to investigate.

OHS' semi annual audit of OSA's records is the discovery strategy related to evidence of participant training on process for reporting REs or complaints.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods

used by the State to document these items.

All incidents and complaints are logged into the Reportable Events manual tracking system. If an incident/complaint has not been resolved in the required timeframe of 45 days, an investigation is initiated to determine the status of the case. Findings are documented in the RE form and tracking system.

The OSA requires providers to correctly report events discovered during the quarterly case management visits that were not reported according to RE policy. Providers who fail to comply with the RE policy are reported to the Office of Health Care Quality and, if appropriate, sanctions are implemented.

When OHS, during the semi annual audit of the OSA's files, discovers that waiver participants have not received the required training related to reporting of events and complaints, the OSA is required to correct the problem by providing the RE education and submitting evidence of the correction in a CAP to OHS within 30 days.

ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify:  1- annual provider audits staggered throughout the year 2- semi annual OHS audit

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves

desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

## Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

MHA TBI Waiver Program staff comprised of the Chief, Long Term Care and the TBI Waiver Case Manager and the Office of Health Services, Division of Evaluation and Quality Review, are responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. TBI waiver staff are trained to ensure all system improvements of the TBI Waiver are implemented and continuously monitored and identified problems are addressed.

Regular reporting and communications among TBI Waiver providers, TBI waiver staff, Office of Health Services, the Utilization Control Agent, and other stakeholders including the TBI waiver advisory council and the Waiver Quality Council facilitates ongoing discovery and remediation. MHA is the lead entity responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data,

which may also include data analysis, trending and the formulation of recommendations for system improvements. These partners include, but are not limited to the Office of Health Care Quality, the Developmental Disabilities Administration, MHA's Administrative Services Organization, participants, family, and the TBI Waiver Advisory Council. A plan to work on significant problem areas may result in the establishment of a specific task group or groups, which could also involve stakeholders.

Data is received, aggregated and analyzed by MHA. Sources of data include but are not limited to: provider applications, provider audits, quarterly site visit reports, Reportable Events and complaints submitted by provider/family/caregivers. Based on the nature of this information, data is disseminated to appropriate staff to be reviewed, prioritized and recorded in the appropriate spreadsheets and logs for analysis. MHA's Chief of Long Term Care reviews data, noting trends and looking for anomalies that may need immediate attention. When data analysis reveals the need for system change, MHA makes recommendations to OHS management and discusses the prioritization of design changes. Plans developed as a result of this process will be shared with stakeholders, primarily through the forum of the Waiver Quality Council, for review and recommendations. Dependent on the nature of the system/program change required, the industry will be notified via DHMH transmittals, letters, memos, email and /or posted on the DHMH-OHS website. Program trends and system changes are reported to stakeholders via the annual tracking and trending report that is generated by MHA.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The efficiency of the waiver quality improvement strategy design is an ongoing process performed by the OHS and MHA Program staff who are responsible for the administration of the waiver, the implementation of program improvement strategies and subsequent assessment of their effectiveness. Data from RE reports are reviewed quarterly and data derived from MHA provider audits are assessed when they have been completed. The MHA and OHS participant and provider audits occur annually. Other oversight activities occur at pre-determined intervals. If a system change is needed, the OHS and MHA design the plan and implement the system change. Program staff provide data analysis on the change and its efficiency or effectiveness, post implementation. Data post system change will be reported during interagency coordination meetings. Once reviewed and analyzed a report compiling outcomes will be written. Data related to the change will be shared verbally and by written report with the Waiver Quality Council and other stakeholders who are engaged in the formulation of program strategies.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Administering waiver staff continuously evaluate the effectiveness and relevance of the quality improvement strategy with input from participants, providers, and other stakeholders. Through the continuous process of discovery, vital information will flow into the waiver from many sources, such as, reportable events, waiver performance measures, case manager quarterly reports, provider licensure data, complaint surveys/reports, Fair Hearings and provider audits. If the quality improvement strategy is not working as it should be, the repetition of issues and problems and unsuccessful improvement will indicate that the quality management plan must be reconfigured. Immediate Actions will be taken to remediate any identified issues that require remediation. To provide structure to the periodic evaluation of the quality improvement strategy, SMA and OSA program staff will routinely involve the Waiver Quality Council. The Waiver Quality Council conducts quarterly meetings and/or communicates with the council representatives to address any

specific areas of concern based on shared data including any changes in a waiver's quality improvement strategy plan.

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Single State Audit:** There is an annual independent audit of Maryland's Medical Assistance Program that includes Medicaid home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by Maryland's Comptroller's Office. The present contractor is Abrams, Foster, Nole, and Williams.

**Department of Legislative Services:** The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid and the Mental Hygiene Administration are audited on a two-year cycle.

**Mental Hygiene Administration:** MHA reviews the claims paid for authorized services to TBI waiver providers. In doing the claims review, if further evaluation of billing is warranted, MHA's Office of Compliance will conduct on-site audits.

**Audit of Provider Agencies:** Medicaid has no requirement for HCBS waiver providers to obtain independent financial audits. If there are concerns about a provider's billing, the Division of Evaluation and Quality Review will refer the provider for an audit by Medicaid auditing staff or to the Department's Office of the Inspector General. A referral may also be made to the Medicaid Fraud Control Unit which also may conduct audits when there is a strong likelihood of fraud.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

#### a. Methods for Discovery: Financial Accountability

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### **Performance Measure:**

**Number and percent of waiver claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved TBI waiver; Numerator- number of claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved TBI waiver; Denominator- total number of paid claims.**

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**ASO monthly claims reports**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**monthly MMIS claims reports**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	<b>Ongoing</b>	Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of system edits determined to be functioning during an annual review. N= number of system edits reviewed annually determined to be functioning, D= Total number of system edits reviewed annually.

**Data Source** (Select one):**Financial audits**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

<input type="text"/>	<input type="text"/>
<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. There are edits in the ASO claims payment system and in MMIS that ensure that TBI waiver claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver. Monitoring of this occurs in two ways. System edits are checked annually and the OSA receives monthly claims reports from the MMIS and from the ASO. These reports are reviewed to ensure that TBI waiver claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If system edits are not functioning properly and it is discovered that claims have been paid that are not in accordance with the reimbursement methodology in the approved waiver, the ASO will initiate a recovery of funds paid to a provider. The ASO will also initiate a recovery of funds for services provided in excess or not in accordance with, the participant's approved plan of care. Technical assistance is provided to the provider by the ASO or the OSA. Continued billing errors may result in referrals to the DHMH Office of Inspector General (OIG). The OIG refers cases to the Medicaid Fraud Control Unit as appropriate.

The primary general method for problem correction in this area is provider group training by the ASO on Medicaid waiver billing. Additionally, the ASO distributes Billing Instruction Guidelines via "provider alert" to all providers and



updates them as necessary to reflect changes in the waiver impacting billing and/or to reflect annual rate changes.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☐ **No**

☒ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

ValueOptions (ASO) is in the process of developing the monthly report that will be utilized to monitor that claims are coded and paid accordance with the reimbursement methodology in the approved waiver. A draft report has been provided to MHA for review. Initiation of monthly automated reports to MHA is scheduled to start in July 2011. MMIS monthly reports have been in place since the last renewal.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The initial waiver rates were based on Developmental Disabilities Administration (DDA) rate setting methodology for comparable services. Rates were published in MHA regulations, COMAR 10.21.25. There was a 30 day public comment period. After this period, the rates were adopted effective July 1, 2003. The new rates proposed under this waiver application were calculated based on DDA rates for comparable in-home services and computing a statewide average. The State used the same methodology in 2006 for first renewal and will again use this methodology for rate determination in the 2011 renewal. MHA amends the rate section of its regulation as rate changes occur. There is a 30 day comment period as required by law. Payment rate information is reflected on the revised plan of care for each participant.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

TBI waiver providers submit claims to ValueOptions, the limited fiscal agent, an entity under contract to MHA, for claims

processing. ValueOptions pays clean claims and submits appropriate claims to MMIS for receipt of FFP.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** (*select one*):

- ☒ **No. State or local government agencies do not certify expenditures for waiver services.**
- ☐ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Payments for all waiver services are made through the approved Medicaid Management Information System (MMIS). The claim for Federal Funds Participation (FFP) is based on the initial processing of the provider claim by the limited fiscal agent (MAPS-MD) and the subsequent review of the provider claim by the Medicaid agency. MMIS edits each claim to validate the participant's waiver eligibility on the date of service. The claim is also edited for any service limitations that are specified in the TBI Waiver regulations, such as day habilitation and supported employment on the same day. Requests are made for federal financial participation based on claims processed through the MMIS. During the quarterly participant site visit, the TBI Waiver Case Manager validates that the participant is receiving the services indicated in the plan of care by interviewing the participant, provider agency staff and reviewing the medical record. The claim is based on the review of the paid provider claim by Medicaid. Consumer eligibility information is maintained by Medicaid and provided to MAPS-MD on a daily basis. The eligibility information within the MAPS-MD claims processing information is updated on a daily basis based on the consumer data as provided by MAPS-MD. The information includes both the service plan and the effective dates of

coverage. The claims are subject to the full edits of the MAPS-MD system. Claims eligible for FFP are submitted by MAPS-MD to the Medicaid system for additional review and for the collection of FFP.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☒ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the

operations of the limited fiscal agent:

ValueOptions is the limited fiscal agent under contract from MHA. ValueOptions' functions are to enroll eligible providers, verify authorization prior to payment, review claims and pay only Medicaid approved TBI waiver rates on clean claims submitted by eligible TBI waiver providers, provide data analysis, and conduct evaluations. The Medicaid agency oversees the claims payment system through a review of all claims paid through the limited fiscal agent. MHA instructs all TBI waiver providers to bill through MHA's ASO. MHA conducts retrospective compliance reviews of a sample of TBI waiver claims.

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

- c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ☒ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ☐ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

- d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ☒ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ☐ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

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**Appendix I: Financial Accountability**

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**I-3: Payment (5 of 7)****e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

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- ☐ The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

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**Appendix I: Financial Accountability**

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**I-3: Payment (6 of 7)****f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ☐ Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- ☐ Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

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**Appendix I: Financial Accountability**

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**I-3: Payment (7 of 7)****g. Additional Payment Arrangements****i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ☒ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System. *Select one:***

- ☒ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

- ☒ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☒ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the

non-federal share of computable waiver costs. *Select at least one:*

- ☒ **Appropriation of State Tax Revenues to the State Medicaid agency**  
☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- ☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.  
☐ **Applicable**

*Check each that applies:*

- ☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- ☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:



## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

*Check each that applies:*

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings.** *Select one:*

☐ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

☒ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The cost of room and board is excluded from TBI waiver service rates. Waiver providers are expected to bill waiver participants for room and board expenses. Upon enrollment in the program, waiver providers sign an agreement that states that room and board costs are not included in TBI waiver rates and waiver participants will be billed for room and board costs. The charge cannot exceed \$420.00 monthly. Additionally, MHA sends a letter to waiver providers indicating the waiver services that are authorized for each waiver participant as they are enrolled in the program and as services change or are re-authorized thereafter. This letter also states that the waiver provider will charge room and board costs to the waiver participant.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

☒ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

☐ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in**



**Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ☒ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ☐ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
- i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):***

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.**
- ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- ☒ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☐ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration****J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care:** Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	81265.91	3732.35	84998.26	205174.27	8906.56	214080.83	129082.57
2	72788.46	4059.68	76848.14	217400.50	9098.52	226499.02	149650.88
3	71548.26	4415.71	75963.97	223879.10	9193.34	233072.44	157108.47

4	69962.41	4802.97	74765.38	231977.55	9397.07	241374.62	166609.24
5	69900.95	5224.19	75125.14	240307.24	9600.94	249908.18	174783.04

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	64	10	54
Year 2	76	12	64
Year 3	88	13	75
Year 4	100	15	85
Year 5	112	17	95

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Using enrollment data and information from the FY2008, FY2009 and FY2010 372, we projected an average length of stay of 314 days in Waiver Year 1, 321 days in Waiver Year 2, 324 days in Waiver Year 3, 320 days in Waiver Year 4 and 322 days in Waiver Year 5.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

We derived Factor D using the 372 data and projections of program utilization. The following are our assumptions:

**NUMBER OF USERS:**

- 64 users in waiver year 1 and an increase of 12 users per year for the remainder of the waiver years.
- 54 users at nursing facility level of care, 10 at chronic hospital level of care.
- 36 users of residential habilitation in Waiver Year 1 and all users in day habilitation.

**AVERAGE UNITS PER USER:**

- 42 users of day habilitation:
  - o 42 users will utilize day habilitation 5 days per week.
- Waiver Year 1: 36 users of residential habilitation every day for the length of stay. 3 users (one user from residential habilitation level 1 and two users from residential habilitation level 2) will “step down” to individual support services after 2 months of residential habilitation.
- Waiver Year 2-5: 39 users of residential habilitation every day for the length of stay. 4 users of individual support services in Waiver year 1 will utilize 7 hours per day, 7 days per week. The number of users of ISS will increase by 1 user for each of the remainder of the waiver years.

**UNIT COST:**

- 1 percent provider rate decrease in Waiver Year 1 and a 2.5 increase each year in Waiver Year 2 through Waiver Year 5.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

We derived D' using the actual expenditures for D' services as reported on the 372 for chronic hospital and nursing facility level of care. Approximately half the waiver users are enrolled in managed care organizations; therefore, we inflated the cost from the 372 by the average rate of growth in managed care reimbursement rates over the past three years.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Nursing facility level of care and chronic hospital level of care projections were projected using separate methodologies:

**Nursing facility LOC:**

We derived G using the Medicaid average daily rate in 2011 at the state owned and operated nursing facilities (Deer's Head Hospital Center and Western Maryland Center licensed as Medicaid skilled nursing facilities) and at Quality Living, Inc (a CARF-accredited nursing facility for traumatic brain injury patients). We inflated the 2009 daily rates by the average Medicaid nursing facility increase (for these specific facilities) over the last three years - a 3.5% increase per year.

**Chronic hospital LOC:**

To derive G for chronic hospital level of care, we created a special report of chronic hospital cost and bed days for TBI patients in fiscal year 2009. The report calculated costs for facility claims for adult patients with ICD-9 codes 800.0-801.9, 803.0-804.9, 850.0-854.1. We inflated the fiscal year 2009 dollars by the average annual increase of chronic hospital costs - 3.5%.

After calculating costs for the two levels of care individually, we calculated the weighted average of the two levels of care. The weighted average calculation appears in the Appendix J-1 Table.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Nursing facility level of care and chronic hospital level of care projections were projected using separate methodologies:

**Nursing facility LOC:**

We derived Factor G' using the Medicaid average daily rate of all non-nursing facility services provided to individuals in the state owned and operated nursing facilities listed above - Deer's Head Hospital Center and Western Maryland Center. The daily rate was inflated annually by the predicted average yearly increase in cost of 2% based on the Consumer Price index for medical care in the Washington-Baltimore area.

**Chronic hospital LOC:**

Using the same individuals identified in Factor G (Chronic hospital LOC with specified ICD-9 codes), we derived Factor G' by calculating the average cost of all non-facility services delivered to these individuals. The daily rate was inflated annually by the predicted average yearly increase in cost of 2% based on the Consumer Price index for medical care in the Washington-Baltimore area.

After calculating non-facility costs for the two levels of care individually, we calculated the weighted average of non-

facility costs for the two levels of care. The weighted average calculation appears in the Appendix J-1 Table.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Day Habilitation
Individual Support Services
Medical Day Care
Residential Habilitation
Supported Employment

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						915557.86
Day Habilitation Level 1	1 Day	2	185.00	47.62	17619.40	
Day Habilitation Level 2	1 Day	29	243.00	83.08	585464.76	
Day Habilitation Level 3	1 Day	11	243.00	116.90	312473.70	
<b>Individual Support Services Total:</b>						164291.40
Individual Support Services	1 Hour	3	2380.00	23.01	164291.40	
<b>Medical Day Care Total:</b>						0.00
Medical Day Care	1 Day	0	0.00	71.08	0.00	
<b>Residential Habilitation Total:</b>						4116549.88
Residential Habilitation Level 1	1 Day	2	340.00	184.49	125453.20	
Residential Habilitation Level 2	1 Day	34	354.00	273.98	3297623.28	
Residential Habilitation Level 3	1 Day	6	342.00	337.95	693473.40	

<b>Supported Employment Total:</b>						<b>4619.14</b>
Supported Employment Level 1	1 Day	0	0.00	28.26	0.00	
Supported Employment Level 2	1 Day	1	97.00	47.62	4619.14	
Supported Employment Level 3	1 Day	0	0.00	116.89	0.00	
<b>GRAND TOTAL:</b>						5201018.28
Total Estimated Unduplicated Participants:						64
Factor D (Divide total by number of participants):						81265.91
Average Length of Stay on the Waiver:						314

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						<b>1019153.14</b>
Day Habilitation Level 1	1 Day	2	185.00	49.30	18241.00	
Day Habilitation Level 2	1 Day	31	243.00	86.02	647988.66	
Day Habilitation Level 3	1 Day	12	243.00	121.03	352923.48	
<b>Individual Support Services Total:</b>						<b>227718.40</b>
Individual Support Services	1 Hour	4	2380.00	23.92	227718.40	
<b>Medical Day Care Total:</b>						<b>0.00</b>
Medical Day Care	1 Day	0	0.00	73.60	0.00	
<b>Residential Habilitation Total:</b>						<b>4280269.62</b>
Residential Habilitation Level 1	1 Day	2	340.00	191.01	129886.80	
Residential Habilitation Level 2	1 Day	37	354.00	252.92	3312746.16	
Residential Habilitation Level 3	1 Day	7	342.00	349.89	837636.66	
<b>Supported Employment Total:</b>						<b>4782.10</b>
Supported Employment Level 1	1 Day	0	0.00	29.26	0.00	
Supported Employment Level 2	1 Day	1	97.00	49.30	4782.10	
Supported Employment Level 3					0.00	

	1 Day	0	0.00	121.02		
GRAND TOTAL:						5531923.26
Total Estimated Unduplicated Participants:						76
Factor D (Divide total by number of participants):						72788.46
Average Length of Stay on the Waiver:						321

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						1147783.45
Day Habilitation Level 1	1 Day	2	185.00	50.53	18696.10	
Day Habilitation Level 2	1 Day	33	243.00	88.17	707035.23	
Day Habilitation Level 3	1 Day	14	243.00	124.06	422052.12	
<b>Individual Support Services Total:</b>						291788.00
Individual Support Services	1 Hour	5	2380.00	24.52	291788.00	
<b>Medical Day Care Total:</b>						0.00
Medical Day Care	0	0	0.00	75.43	0.00	
<b>Residential Habilitation Total:</b>						4851773.04
Residential Habilitation Level 1	1 Day	3	340.00	195.78	199695.60	
Residential Habilitation Level 2	1 Day	40	354.00	259.24	3670838.40	
Residential Habilitation Level 3	1 Day	8	342.00	358.64	981239.04	
<b>Supported Employment Total:</b>						4902.38
Supported Employment Level 1	1 Day	0	0.00	30.00	0.00	
Supported Employment Level 2	1 Day	1	97.00	50.54	4902.38	
Supported Employment Level 3	1 Day	0	0.00	124.50	0.00	
GRAND TOTAL:						6296246.87
Total Estimated Unduplicated Participants:						88
Factor D (Divide total by number of participants):						71548.26
Average Length of Stay on the Waiver:						324

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (8 of 9)****d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						<b>1250791.15</b>
Day Habilitation Level 1	1 Day	2	185.00	50.53	18696.10	
Day Habilitation Level 2	1 Day	35	243.00	90.37	768596.85	
Day Habilitation Level 3	1 Day	15	243.00	127.16	463498.20	
<b>Individual Support Services Total:</b>						<b>358856.40</b>
Individual Support Services	1 Hour	6	2380.00	25.13	358856.40	
<b>Medical Day Care Total:</b>						<b>0.00</b>
Medical Day Care	1 Day	0	0.00	77.32	0.00	
<b>Residential Habilitation Total:</b>						<b>5380987.02</b>
Residential Habilitation Level 1	1 Day	3	340.00	200.68	204693.60	
Residential Habilitation Level 2	1 Day	43	354.00	265.72	4044789.84	
Residential Habilitation Level 3	1 Day	9	342.00	367.61	1131503.58	
<b>Supported Employment Total:</b>						<b>5606.60</b>
Supported Employment Level 1	1 Day	0	0.00	30.75	0.00	
Supported Employment Level 2	1 Day	1	97.00	57.80	5606.60	
Supported Employment Level 3	1 Day	0	0.00	127.15	0.00	
<b>GRAND TOTAL:</b>						<b>6996241.17</b>
<b>Total Estimated Unduplicated Participants:</b>						<b>100</b>
<b>Factor D (Divide total by number of participants):</b>						<b>69962.41</b>
<b>Average Length of Stay on the Waiver:</b>						<b>320</b>

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (9 of 9)****d. Estimate of Factor D.**



**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Day Habilitation Total:</b>						<b>1390914.17</b>
Day Habilitation Level 1	1 Day	2	185.00	53.09	19643.30	
Day Habilitation Level 2	1 Day	37	243.00	92.63	832836.33	
Day Habilitation Level 3	1 Day	17	243.00	130.34	538434.54	
<b>Individual Support Services Total:</b>						<b>429161.60</b>
Individual Support Services	1 Hour	7	2380.00	25.76	429161.60	
<b>Medical Day Care Total:</b>						<b>0.00</b>
Medical Day Care	0	0	0.00	79.25	0.00	
<b>Residential Habilitation Total:</b>						<b>6003681.08</b>
Residential Habilitation Level 1	1 Day	4	340.00	205.70	279752.00	
Residential Habilitation Level 2	1 Day	46	354.00	272.37	4435273.08	
Residential Habilitation Level 3	1 Day	10	342.00	376.80	1288656.00	
<b>Supported Employment Total:</b>						<b>5149.73</b>
Supported Employment Level 1	1 Day	0	0.00	31.51	0.00	
Supported Employment Level 2	1 Day	1	97.00	53.09	5149.73	
Supported Employment Level 3	1 Day	0	0.00	130.33	0.00	
<b>GRAND TOTAL:</b>						<b>7828906.58</b>
Total Estimated Unduplicated Participants:						<b>112</b>
Factor D (Divide total by number of participants):						<b>69900.95</b>
Average Length of Stay on the Waiver:						<b>322</b>